Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CURT E COOK DC
4303 VICTORY DRIVE
AUSTIN TX 78704

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-2130-01

MFDR Date Received
APRIL 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Chartis continued to deny this claim no matter how many times I've corrected it."

Amount in Dispute: $1,443.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier did not pay the $1,443.50 disputed services as the services provided are beyond the scope of practice for a doctor of chiropractic…the Texas Third Court of Appeals ruled…that a doctor of chiropractic could not perform a needle EMG or manipulation under anesthesia."

Response Submitted By: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2012	Office Visit - CPT Code 99211	$30.70	$0.00
	Nerve Conduction Studies - CPT Code 95900-59 (X2)	$96.90/each	$0.00
	Nerve Conduction Studies - CPT Code 95904 (X4)	$85.00/each	$367.93
	Needle EMG - CPT Code 95886 (X2)	$127.50/each	$0.00
	Nerve Conduction Studies - CPT Code 95903 (X4)	$111.00/each	$485.91
	H-Reflex Study - CPT Code 95934 (X2)	$90.00/each	$199.31
TOTAL		$1,443.50	$1,053.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. 22 Texas Administrative Code §75, effective December 24, 2009, *34 Texas Register 9208*, sets out the scope of practice for chiropractors.
4. District Court of Travis County, 250th Judicial District No. D-1-N-GN-06-003451, Honorable Stephen Yelenosky, Judge Presiding, Order on cross-motions for partial summary judgment dated November 24, 2009.
5. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012.
6. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Mandate dated August 8, 2013.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 185-The rendering provider is not eligible to perform the service billed.
- VH04-Service does not fall within the scope of the providers practice.
- W1-Workers compensation state fee schedule adjustment.
- VRNA-No reduction available.
- Z710-The charge for this procedure exceeds the fee schedule allowance.
- 16-Claim service lacks information which is needed for adjudication.
- VH06-Provider name on bill does not match provider name on the medical records submitted.
- X394-Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution
- Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

Litigation Background for Needle EMG and MUA

Portions of the Texas Board of Chiropractic Examiners rules of practice were challenged by the Texas Medical Association and the Texas Medical Board in 2009. At issue was whether 22 Texas Administrative Code §75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) were within the scope of chiropractic practice in Texas. Specifically, the parties sought judgment on whether rules allowing Chiropractors to perform needle electromyography (EMG) and manipulation under anesthesia (MUA) were valid. On November 24, 2009, the 345th District Court issued a judgment in which presiding judge Honorable Stephen Yelenosky concluded that needle EMG and MUA exceeded the statutory scope of chiropractic practice in Texas. The Texas Board of Chiropractic Examiners appealed the district court's judgment to the Texas Court of Appeals, Third District. The Texas Court of Appeals in *Tex. Bd. Of Chiropractic Examiners v. Tex. Med. Ass'n*., 375 S.W.3d 464 (Tex. App. – Austin, 2012, pet. den.) issued an opinion affirming the district court's judgment, and concluding that needle EMG and MUA services are not within the chiropractic scope-of-practice. The Chiropractic Board exhausted its appeals and on August 8, 2013, the mandate affirming the district court's judgment was issued. The mandate states "…we affirm the remainder of the district court's judgment that subparts 75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) of the Texas Board of Chiropractic Examiners' scope-of-practice rule are void." In accordance with the Texas Court of Appeals opinion, the final mandate, and the scope of chiropractic practice requirement in 28 Texas Administrative Code §134.203(a)(6), needle EMG and MUA services may not be reimbursed.

Issues

1. Is the rendering provider eligible to perform needle electromyography?
2. Is the rendering provider entitled to reimbursement for the office visit?
3. Is the rendering provider eligible to perform nerve conduction tests?
4. Is the allowance for CPT code 95900 included in the allowance for code 95903?
5. Is the requestor entitled to reimbursement for CPT codes 95934, 95903, and 95904?

Findings

1. CPT code 95886 is defined as "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, 5 or more muscles studied, innervated by 3 or more nerves or 4 or more spinal levels (List separately in addition to code for primary procedure)." According to the medical documentation found, this service was performed by Curt E. Cook, DC (Doctor of Chiropractic). The Texas Court of Appeals in *Tex. Bd. Of Chiropractic Examiners v. Tex. Med. Ass'n*., 375 S.W.3d 464 (Tex. App. – Austin, 2012, pet. den.) issued an opinion affirming the district court's judgment, and concluding that needle EMG and MUA services are not within the chiropractic scope-of-practice of chiropractors. 28 Texas Administrative Code §134.203(a)(6) states

”Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.” The division finds that disputed service code 95886 is not within the scope of chiropractic practice because it is an electro-diagnostic test that involves the insertion of a needle into the patient. Therefore, no reimbursement can be recommended for CPT code 95886 pursuant to 28 Texas Administrative Code §134.203(a)(6).

2. According to the explanation of benefits, the respondent denied reimbursement for the disputed office visit based upon reason codes “W1 and 16.”

   CPT code 99211 is defined as “Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.”

   The requestor appended modifier “25” to CPT code 99211.

   The Medicare General Correct Coding Policy Manual effective January 1, 2012 states “**Modifier 25**: The *CPT Manual* defines modifier 25 as a “significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service”. Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s).

   The Division finds that the report does not support a significant separate identifiable evaluation and management service; therefore, per 28 Texas Administrative Code §134.203(a)(6) reimbursement is not recommended.

3. Disputed services 95900, 95903, 95904, and 95934 fall in the category of nerve conduction tests under applicable AMA current procedural terminology (CPT). These tests involve placing a stimulating electrode is directly over the nerve to be tested. These are surface tests that do not involve needles. According to the medical documentation found, these services were performed by Curt E. Cook, D.C. (Doctor of Chiropractic). As stated in the Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012

   > In the second provision, paragraph(c)(3)(A), TBCE imposed certification and supervision requirements on any licenses who administered “electro-neuro diagnostic testing” that varied according to whether the testing was “surface (non-needle)” or involved the use of needles. The import or effect of paragraphs (c)(2)(D) and (c)(3)(A), as the parties agree, was that chiropractors with specified training and certification could utilize needle EMG in evaluating or examining patients. In their live petitions and summary-judgment motions, the Physician Parties challenged the validity of the two rule provisions **specifically addressing needle EMG** [emphasis added]- 75.17(c)(2)(D) and (c)(3)(A) – plus the general standard regarding use of needles-75.17(a)(3).”

   That is, surface tests were not in question during this suit. Pursuant to §75.17(c)(3)(A) effective December 24, 2009, *34 Texas Register 9208*, services 95900, 95903, 95904, and 95934 are within the scope of chiropractic practice because they are surface tests. Reimbursement is recommended for these services in accordance to Division rules and guidelines.

4. 28 Texas Administrative Code §134.203(a)(5), states “‘Medicare payment policies’ when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

   Per The National Correct Coding Initiative Policy Manual “The NCCI edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 95900 of this NCCI edit is appropriate only if the two procedures are performed on different nerves or at separate patient encounters.” The requestor utilized modifier 59 to indicate that CPT code 95900 was a separate procedure. A review of the submitted report, does not support that the testing were to different nerves or a separate patient encounter; therefore, reimbursement is not recommended.

5. Because these studies, CPT codes 95934, 95903, and 95904, are within the scope of chiropractic practice reimbursement is recommended in accordance with 28 Texas Administrative Code §134.203(c).

   Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2012 DWC conversion factor for this service is 54.86.

The Medicare Conversion Factor is 34.0376

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78704, which is located in Austin, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Austin, Texas.

Using the above formula, the Division finds the following:

Code	Calculation for Locality Austin	Maximum Allowable
95903	(54.86/34.0376) x $75.37 for 4 Units	$485.91
95904	(54.86/34.0376) x $57.07 for 4 Units	$367.93
95934	(54.86/34.0376) x $61.83 for 2 Unit	$199.31
		$1,053.15

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is $1,053.15.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,053.15 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/09/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.